		FOR OHF USE					

LL1

2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044198

Facility Name: NORTHWOODS CARE CENTRE

Address: 2250 S. PEARL STREET (Number) BELVIDERE (City) 61108 (Zip Code)

County: BOONE

Telephone Number: (815) 544-0358 **Fax #** (815) 544-5006

IDPA ID Number: 36-3954529

Date of Initial License for Current Owners: 06/01/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2004 to 12/31/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) SHAEL BELLOWS
(Title) MANAGEMENT CONSULTANT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)
(Print Name and Title) BOB KAGDA, PARTNER
(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124
(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	116	Skilled (SNF)	116	42,456	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	116	TOTALS	116	42,456	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	12,155	4,774	3,791	20,720	8
9	SNF/PED					9
10	ICF	12,607	4,896	1,073	18,576	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	24,762	9,670	4,864	39,296	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.56%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/01/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/01/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 116 and days of care provided 2,374

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 12/31/2004 Fiscal Year: 12/31/2004

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	172,136	12,175	9,495	193,806		193,806	(1,371)	192,435			1
2	Food Purchase		137,799		137,799		137,799	(1,068)	136,731			2
3	Housekeeping	227,560	27,638		255,198		255,198	(4,541)	250,657			3
4	Laundry	36,734	22,441	716	59,891		59,891	(1,155)	58,736			4
5	Heat and Other Utilities			98,503	98,503		98,503		98,503			5
6	Maintenance	10,158	14,777	29,037	53,972		53,972	3,637	57,609			6
7	Other (specify):*			4,192	4,192		4,192		4,192			7
8	**TOTAL General Services**	446,588	214,830	141,943	803,361		803,361	(4,498)	798,863			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	1,397,764	72,695	58,146	1,528,605		1,528,605	(23,056)	1,505,549			10
10a	Therapy			1,550	1,550		1,550		1,550			10a
11	Activities	133,845	6,838	2,487	143,170		143,170	(1,526)	141,644			11
12	Social Services	45,343		716	46,059		46,059		46,059			12
13	Nurse Aide Training			372	372		372		372			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,576,952	79,533	71,071	1,727,556		1,727,556	(24,582)	1,702,974			16
	C. General Administration											
17	Administrative	95,929		423,400	519,329		519,329	(411,362)	107,967			17
18	Directors Fees											18
19	Professional Services			173,296	173,296		173,296	(106,820)	66,476			19
20	Dues, Fees, Subscriptions & Promotions			41,271	41,271		41,271	(26,432)	14,839			20
21	Clerical & General Office Expenses	92,017	30,589	30,134	152,740		152,740	98,949	251,689			21
22	Employee Benefits & Payroll Taxes			426,919	426,919		426,919		426,919			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,135	6,135		6,135	6,719	12,854			24
25	Other Admin. Staff Transportation			3,472	3,472		3,472		3,472			25
26	Insurance-Prop.Liab.Malpractice			103,869	103,869		103,869	11,843	115,712			26
27	Other (specify):*			16,486	16,486		16,486	(16,486)				27
28	**TOTAL General Administration**	187,946	30,589	1,224,982	1,443,517		1,443,517	(443,589)	999,928			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,211,486	324,952	1,437,996	3,974,434		3,974,434	(472,669)	3,501,765			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID#: NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning: 01/01/2004** **Ending: 12/31/2004**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	9,495	
	REPAIRS & MAINTENANCE		0	
			0	9,495
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		716	
			0	716
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		41,036	
	ELECTRICITY		34,315	
	WATER		22,469	
	CABLE TV - LOBBY		683	
			0	98,503
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		2,990	
	PAINTING & DECORATING		396	
	BUILDING REPAIRS		0	
	MAINTENANCE TRAVEL		0	
	EQUIPMENT MAINTENANCE & REPAIR		20,331	
	ELEVATOR MAINTENANCE & REPAIR		3,497	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		421	
	FIRE SERVICE		1,402	
			0	
			0	
			0	29,037
7	**OTHER**			
	SCAVENGER		4,192	
	SECURITY SERVICE		0	4,192
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	7,800	7,800

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	0	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B 47-2	12,000	
	RESTORATIVE NURSING CONSULTANT	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	258	
	PHARMACY CONSULTANT	XVIII B 39-2	1,440	
	UTILIZATION REVIEW FEES	XVIII B 48-2	7,800	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	36,648	
			0	
			0	58,146
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		0	
	SPEECH THERAPY SERVICES		0	
	OCCUPATIONAL THERAPY SERVICES		0	
	REHABILITATION CONSULTANT	XVIII B __-2	0	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	1,550	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	0	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	1,550
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	2,487	
			0	2,487
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	716	
			0	716
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	372	372

Facility Name & ID Number NORTHWOODS CARE CENTRE **#0044198** **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	423,400	423,400
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	22,637	
	ADMINISTRATIVE CONSULTANTS	XIX C	0	
	PROFESSIONAL FEES	XIX C	150,659	
			0	173,296
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	11,039	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	9,841	
	EMPLOYEE WANT ADS	XIX F	2,736	
	CONTRIBUTIONS	VI 20 XIX F	476	
	DUES & SUBSCRIPTIONS	XIX F	6,082	
	LICENSES & PERMITS	XIX F	3,025	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	0	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	5,720	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	2,352	41,271
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)		5,334	
	EQUIPMENT REPAIR & MAINTENANCE		2,200	
	OUTSIDE CLERICAL SERVICES		0	
	PENALTIES / OVERDRAFT CHARGES	VI 18	3	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		22,116	
	MESSENGER SERVICE		481	
			0	30,134

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	167,286	
	UNEMPLOYMENT COMPENSATION	XIX D	30,634	
	WORKERS COMPENSATION INSURANCI	XIX D	45,905	
	HOSPITALIZATION INSURANCE	XIX D	161,589	
	EMPLOYEE BENEFITS - OTHER	XIX D	10,900	
	EMPLOYEE PHYSICAL EXAMS	XIX D	2,655	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	PENSION/PROFIT SHARING PLANS	XIX D	7,950	
	CHICAGO HEAD TAX	XIX D	0	426,919
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		0	0
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G	6,135	
	TRAVEL	XIX G	0	
			0	
			0	6,135
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		3,472	3,472
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		103,869	103,869
27	**OTHER**			
	BAD DEBTS	VI 24	16,486	
				16,486

GRAND TOTAL COLUMN 3 OTHER 1,437,996

NORTHWOODS CARE CENTRE
EMPLOYEE MEAL RECLASSIFICATION (PAGE 3 SCHEDULE V COLUMN 5 LINES 2 AND 22)
12/31/2004

TOTAL FOOD PURCHASE	137,799	PATIENT MEALS	117888
LESS SALES TAX	(1,068)	ADD EMPLOYEE MEALS	0
NET FOOD	136,731	TOTAL MEALS/YEAR	117888
TOTAL PATIENT CENSUS	39,296	NET FOOD	136731
TIME 3 MEALS PER DAY	3	DIVIDE TOTAL MEALS/YEAR	117888
TOTAL PATIENT MEALS	117888	COST PER MEAL	1.16
		TIME EMPLOYEE MEALS	0
ADD # EMPLOYEE MEALS/DAY	0		
TIME # DAYS	366	EMPLOYEE MEAL RECLASSIFICATION	0
TOTAL EMPLOYEE MEALS	0		

Facility Name & ID Number NORTHWOODS CARE CENTRE #0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			83,514	83,514		83,514	40,434	123,948			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			8,739	8,739		8,739	57,773	66,512			32
33	Real Estate Taxes			70,676	70,676		70,676		70,676			33
34	Rent-Facility & Grounds			438,000	438,000		438,000	(414,605)	23,395			34
35	Rent-Equipment & Vehicles			23,961	23,961		23,961	5,290	29,251			35
36	Other (specify):* STORAGE			2,224	2,224		2,224		2,224			36
37	**TOTAL Ownership**			627,114	627,114		627,114	(311,108)	316,006			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		92,334	169,329	261,663		261,663		261,663			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			63,684	63,684		63,684		63,684			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		92,334	233,013	325,347		325,347		325,347			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,211,486	417,286	2,298,123	4,926,895		4,926,895	(783,777)	4,143,118			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(40,758)	30		9
10	Interest and Other Investment Income	(52,413)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,068)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees		20		17
18	Fines and Penalties	(3)	21		18
19	Entertainment	(11,039)	20		19
20	Contributions	(6,196)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(16,486)	27		24
25	Fund Raising, Advertising and Promotional	(9,841)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(17,322)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (155,126)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(628,651)	PG 6-6E	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (628,651)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (783,777)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

NORTHWOODS CARE CENTRE

ID# 0044198

Report Period Beginning: 01/01/2004

Ending: 12/31/2004

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 802	6	1
2	VACATION ACCRUAL	(1,371)	1	2
3	VACATION ACCRUAL	(4,541)	3	3
4	VACATION ACCRUAL	(1,155)	4	4
5	VACATION ACCRUAL	2,835	6	5
6	VACATION ACCRUAL	(12,879)	10	6
7	VACATION ACCRUAL	(1,526)	11	7
8	VACATION ACCRUAL	(1,245)	17	8
9	VACATION ACCRUAL	1,758	21	9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(17,322)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(1,371)	0	0	0	0	0	0	0	0	0	0	(1,371)	1
2	Food Purchase	(1,068)	0	0	0	0	0	0	0	0	0	0	(1,068)	2
3	Housekeeping	(4,541)	0	0	0	0	0	0	0	0	0	0	(4,541)	3
4	Laundry	(1,155)	0	0	0	0	0	0	0	0	0	0	(1,155)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	3,637	0	0	0	0	0	0	0	0	0	0	3,637	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(4,498)	0	0	0	0	0	0	0	0	0	0	(4,498)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(12,879)	0	3,219	0	(13,396)	0	0	0	0	0	0	(23,056)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(1,526)	0	0	0	0	0	0	0	0	0	0	(1,526)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	(14,405)	0	3,219	0	(13,396)	0	0	0	0	0	0	(24,582)	16
	C. General Administration													
17	Administrative	(1,245)	0	(198,244)	(158,905)	0	0	(52,968)	0	0	0	0	(411,362)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	13,803	(30,824)	27,447	389	(117,635)	0	0	0	0	0	(106,820)	19
20	Fees, Subscriptions & Promotions	(27,076)	0	371	107	12	154	0	0	0	0	0	(26,432)	20
21	Clerical & General Office Expenses	1,755	86	34,588	181	834	61,505	0	0	0	0	0	98,949	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	3,254	329	1,547	1,589	0	0	0	0	0	6,719	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	7,931	1,613	256	952	1,091	0	0	0	0	0	11,843	26
27	Other (specify):*	(16,486)	0	0	0	0	0	0	0	0	0	0	(16,486)	27
28	TOTAL General Administration	(43,052)	21,820	(189,242)	(130,585)	3,734	(53,296)	(52,968)	0	0	0	0	(443,589)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(61,955)	21,820	(186,023)	(130,585)	(9,662)	(53,296)	(52,968)	0	0	0	0	(472,669)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 **Report Period Beginning:** 01/01/2004 **Ending:** 12/31/2004

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(40,758)	76,604	2,406	0	76	2,106	0	0	0	0	0	40,434	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(52,413)	110,186	0	0	0	0	0	0	0	0	0	57,773	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	(438,000)	10,460	0	670	12,265	0	0	0	0	0	(414,605)	34
35	Rent-Equipment & Vehicles	0	0	2,655	315	1,066	1,254	0	0	0	0	0	5,290	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(93,171)	(251,210)	15,521	315	1,812	15,625	0	0	0	0	0	(311,108)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(155,126)	(229,390)	(170,502)	(130,270)	(7,850)	(37,671)	(52,968)	0	0	0	0	(783,777)	45

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED LIST OF		SEE ATTACHED LIST OF RELATED		NORTHWOODS HEALTHCARE CENTRE		
OWNERS		NURSING HOMES			MORTON GROVE	REAL ESTATE
				SEE ATTACHED LIST OF OTHER RELATED		
				ENTITIES		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENT	$ 438,000	NORTHWOODS HEALTHCARE CENTRE		$	$ (438,000)	1
2	V	19	ACCOUNTING FEES		" "		8,000	8,000	2
3	V	26	MORTGAGE INSURANCE		" "		7,931	7,931	3
4	V	30	DEPRECIATION - BLDG/IMP		" "		75,947	75,947	4
5	V	30	DEPRECIATION - EQPT/FURN		" "		657	657	5
6	V	32	AMORTIZATION - MTG COST		" "		806	806	6
7	V	32	INTEREST - MORTGAGE		" "		109,380	109,380	7
8	V	32	INTEREST - OTHER		" "				8
9	V	19	PROFESSIONAL FEES		" "		5,803	5,803	9
10	V	21	OFFICE EXPENSES		" "		86	86	10
11	V								11
12	V								12
13	V								13
14	Total			$ 438,000			$ 208,610	$ * (229,390)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 604	FHC ENTERPRISES, INC.		$ 3,823	$ 3,219	15
16	V	17	ADMINISTRATIVE	211,527	MR BELLOWS OWNS 1.5% OF THIS FACILITY		13,283	(198,244)	16
17	V	19	PROFESSIONAL FEES	31,047	AND 100% OF FHC ENTERPRISES		223	(30,824)	17
18	V	20	DUES & SUBSCRIPTIONS		" "		371	371	18
19	V	21	CLERICAL		" "		34,588	34,588	19
20	V	24	TRAVEL		" "		3,254	3,254	20
21	V	26	INSURANCE		" "		1,613	1,613	21
22	V	30	DEPRECIATION		" "		2,406	2,406	22
23	V	34	RENT		" "		10,460	10,460	23
24	V	35	RENT - EQPT & VEH		" "		2,655	2,655	24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 243,178			$ 72,676	$ * (170,502)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$	WITTINGHAM MANAGEMENT ASSOCIATES		$ 27,447	$ 27,447	15
16	V	20	DUES & SUBSCRIPTIONS		" "		107	107	16
17	V	21	CLERICAL		" "		181	181	17
18	V	24	TRAVEL		" "		329	329	18
19	V	26	INSURANCE		" "		256	256	19
20	V	35	RENT - EQPT & VEH		" "		315	315	20
21	V	17	ADMINISTRATIVE	158,905	" "			(158,905)	21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 158,905			$ 28,635	$ * (130,270)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING	$ 36,989	CARLYLE NURSING ASSOCIATES, LLC		$ 23,593	$ (13,396)	15
16	V	19	PROFESSIONAL FEES		" "		389	389	16
17	V	20	DUES & SUBSCRIPTIONS		" "		12	12	17
18	V	21	CLERICAL		" "		834	834	18
19	V	24	TRAVEL		" "		1,547	1,547	19
20	V	26	INSURANCE		" "		952	952	20
21	V	30	DEPRECIATION		" "		76	76	21
22	V	34	RENT		" "		670	670	22
23	V	35	RENT - EQPT & VEH		" "		1,066	1,066	23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 36,989			$ 29,139	$ * (7,850)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	PROFESSIONAL FEES	$ 120,861	THE KENSINGTON GROUP, LLC		$ 3,226	$ (117,635)	15
16	V	20	DUES & SUBSCRIPTIONS		" "		154	154	16
17	V	21	CLERICAL		" "		61,505	61,505	17
18	V	24	TRAVEL		" "		1,589	1,589	18
19	V	26	INSURANCE		" "		1,091	1,091	19
20	V	30	DEPRECIATION		" "		2,106	2,106	20
21	V	34	RENT		" "		12,265	12,265	21
22	V	35	RENT - EQPT & VEH		" "		1,254	1,254	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 120,861			$ 83,190	$ * (37,671)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$ 52,968	CHESTERFIELD, LLC		$	$ (52,968)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 52,968			$ 0	$ * (52,968)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	RELATED PARTY - FHC ENTERPRISE								$		1
2	SHAEL BELLOWS	MNGMT CNSLT	ADMIN.	57%	SEE ATTACHED	0.12	0.78	SALARY	13,283	17-7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,283		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: FHC ENTERPRISES, INC.
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	245,034	9	$ 46,961	$ 46,961	19,949	$ 3,823	1
2	17	ADMINISTRATIVE	DIRECT HOURS	1	1	13,283	13,283	1	13,283	2
3	19	PROFESSIONAL FEES	PATIENT DAYS	245,034	9	2,739		19,949	223	3
4	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	245,034	9	4,554		19,949	371	4
5	21	CLERICAL	PATIENT DAYS	245,034	9	99,460		19,949	8,097	5
6	21	CLERICAL	DIRECT HOURS	1	1	26,491	26,491	1	26,491	6
7	24	TRAVEL	PATIENT DAYS	245,034	9	39,971		19,949	3,254	7
8	26	INSURANCE	PATIENT DAYS	245,034	9	19,813		19,949	1,613	8
9	30	DEPRECIATION	PATIENT DAYS	245,034	9	29,557		19,949	2,406	9
10	34	RENT	PATIENT DAYS	245,034	9	128,484		19,949	10,460	10
11	35	RENT - EQUIPMENT & VEH	PATIENT DAYS	245,034	9	32,607		19,949	2,655	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 443,920	$ 86,735		$ 72,676	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: WITTINGHAM MANAGEMENT ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	150,271	5	$ 213,094	$	19,347	$ 27,447	1
2	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	150,271	5	829		19,347	107	2
3	21	CLERICAL	PATIENT DAYS	150,271	5	1,408		19,347	181	3
4	24	TRAVEL	PATIENT DAYS	150,271	5	2,553		19,347	329	4
5	26	INSURANCE	PATIENT DAYS	150,271	5	1,990		19,347	256	5
6	35	RENT - EQPT & VEH	PATIENT DAYS	150,271	5	2,448		19,347	315	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 222,322	$		$ 28,635	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CARLYLE NURSING ASSOC. LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING	PATIENT DAYS	234,229	9	$ 285,631	$ 285,631	19,347	$ 23,593	1
2	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	4,705		19,347	389	2
3	20	DUES & SUBSCRIPTIONS	PATIENT DAYS	234,229	9	142		19,347	12	3
4	21	CLERICAL	PATIENT DAYS	234,229	9	10,102		19,347	834	4
5	24	TRAVEL	PATIENT DAYS	234,229	9	18,724		19,347	1,547	5
6	26	INSURANCE	PATIENT DAYS	234,229	9	11,520		19,347	952	6
7	30	DEPRECIATION	PATIENT DAYS	234,229	9	917		19,347	76	7
8	34	RENT	PATIENT DAYS	234,229	9	8,109		19,347	670	8
9	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	12,901		19,347	1,066	9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 352,751	$ 285,631		$ 29,139	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 2/31/2004

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: THE KENSINTON GROUP, LLC
Street Address: 8140 RIVER DRIVE
City / State / Zip Code: MORTON GROVE, IL 60053
Phone Number: (847) 583-0100
Fax Number: (847) 583-8873

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	PROFESSIONAL FEES	PATIENT DAYS	234,229	9	$ 39,055	$	19,347	$ 3,226	1
2	20	DUES & SURSCRIPTIONS	PATIENT DAYS	234,229	9	1,870		19,347	154	2
3	21	CLERICAL	PATIENT DAYS	234,229	9	744,608	660,461	19,347	61,505	3
4	24	TRAVEL	PATIENT DAYS	234,229	9	19,234		19,347	1,589	4
5	26	INSURANCE	PATIENT DAYS	234,229	9	13,205		19,347	1,091	5
6	30	DEPRECIATION	PATIENT DAYS	234,229	9	25,492		19,347	2,106	6
7	34	RENT	PATIENT DAYS	234,229	9	148,483		19,347	12,265	7
8	35	RENT - EQPT & VEH	PATIENT DAYS	234,229	9	15,176		19,347	1,254	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,007,123	$ 660,461		$ 83,190	25

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE						$	$			$	1
2	GMAC		X	MORTGAGE	$34,916.44	12//03	2,052,500	2,033,708	12/38	5.3500	109,380	2
3	GMAC		X	LOAN COST	AMORT - 35 YEARS		31,305	27,384			806	3
4												4
5												5
	Working Capital											
6	BANK ONE		X	WORKING CAPITAL	VARIES	01/04	1,000,000		DEMAND	PRIME+	8,739	6
7												7
8												8
9	TOTAL Facility Related				$34,916.44		$ 3,083,805	$ 2,061,092			$ 118,925	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,083,805	$ 2,061,092			$ 118,925	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ N/A Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2003 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 71,604	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 70,748	2
3. Under or (over) accrual (line 2 minus line 1).		$ (856)	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 71,532	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 70,676	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1999	67,637	8
	2000	69,802	9
	2001	67,798	10
	2002	70,821	11
	2003	70,748	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2003 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME NORTHWOODS CARE CENTRE COUNTY BOONE

FACILITY IDPH LICENSE NUMBER 0044198

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	07-01-151-003	NURSING HOME	$ 70,748.32	$ 70,748.32
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 70,748.32	$ 70,748.32

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 12,500 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 2/BASEMENT

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME		1981	$ 50,050	1
2	754 BASIS ADJ.		1982	4,835	2
3	TOTALS			$ 54,885	3

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	116		1981		$ 995,068	$	30	$ 33,169	$ 33,169	$ 796,056	4
5	754 BASIS ADJ		1992		111,968	3,555	31.5	3,555		44,435	5
6											6
7											7
8											8
	Improvement Type**										
9	RELATED PARTY - NORTHWOODS HEALTHCARE CENTRE										9
10	VARIOUS IMPROVEMENTS			1981	4,062		15			4,062	10
11	VARIOUS IMPROVEMENTS			1982	73,451		15			73,451	11
12	VARIOUS IMPROVEMENTS			1983	6,203		15			6,203	12
13	VARIOUS IMPROVEMENTS			1984	11,372		20	275	275	11,372	13
14	PAVING			1986	13,000	653	15		(653)	13,000	14
15	SHOWER			1986	4,151	205	25	166	(39)	3,071	15
16	ROOF			1988	38,383	1,219	31.5	1,219		20,164	16
17	DEOCRATING			1989	1,921	61	31.5	61		933	17
18	VARIOUS IMPROVEMENTS			1990	10,047	319	31.5	319		4,785	18
19	VARIOUS IMPROVEMENTS			1991	2,683	85	31.5	85		1,273	19
20	VARIOUS IMPROVEMENTS			1992	38,565	1,224	31.5	1,224		15,062	20
21	CARPET			1993	6,854	217	31.5	217		2,538	21
22	DRIVEWAY			1993	1,655	42	39	42		466	22
23	SPRINKMAN SONS			1993	1,525	39	39	39		400	23
24	VARIOUS IMPROVEMENTS			1994	3,137	209	15	209		2,194	24
25	VARIOUS IMPROVEMENTS			1994	170,951	6,216	27.5	6,216		57,823	25
26	DOORS			1995	5,029	129	39	129		1,271	26
27	LANDSCAPING			1996	51,185	1,861	27.5	1,861		15,486	27
28	ROOF REPAIR			1996	20,000	727	27.5	727		5,923	28
29	DRIVEWAY REPAIR			1996	4,775	174	27.5	174		1,386	29
30	CONCRETE RETAINING WALL FOR RAMP			1997	1,500	55	27.5	55		403	30
31	WALLCOVERING/HANDRAIL/FLOOR TILES			1997	46,256	1,682	27.5	1,682		12,219	31
32	DRYWALL/PAINTING/WALLPAPER INSTALLATION			1997	30,000	1,091	27.5	1,091		7,819	32
33	450000-GRAIN UNITS - WATER SOFTENER/COUNTER TOPS			1997	11,248	409	27.5	409		2,923	33
34	THREE WAY OVER BED RESIDENT LIGHTING			1998	12,600	458	27.5	458		2,869	34
35	GARBAGE DISPOSAL - KITCHEN REMODELING			1998	1,189	43	27.5	43		278	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	WINDOWS AND AUTO DOOR SYSTEM	1998	$ 25,000	$ 909	27.5	$ 909	$	$ 5,719	37
38	WALLCOVERINGS/CARPET/FLOOR TILES/GUARD RAILS	1998	68,941	2,507	27.5	2,507		16,856	38
39	TILES	1998	3,164	115	27.5	115		762	39
40	WOOD FLOORING	1998	4,705	171	27.5	171		1,104	40
41	COUNTER TOPS	1998	17,763	646	27.5	646		4,167	41
42	ELECTRICAL WIRING	1998	3,675	134	27.5	134		876	42
43	REMODELING - PAINTING/DRYWALL/WALLPAPER	1998	125,000	4,545	27.5	4,545		29,302	43
44	WALLCOVERING/TILES/HAND RAILS	1999	29,035	1,056	27.5	1,056		6,292	44
45	REMODELING - HALLS/REHAB/OFFICES/WASHROOMS	1999	100,000	3,636	27.5	3,636		21,362	45
46	TILES	1999	3,924	143	27.5	143		733	46
47	STAINLESS STEEL WALLS IN THE KITCHEN	1999	2,628	96	27.5	96		492	47
48	REMODELING - ARCHITECTURE	2000	4,000	145	27.5	145		719	48
49	BLACKTOP STRIPPING & SEALING	2000	4,050	270	15	270		1,215	49
50	AIRTHERM HEATERS	2000	34,363	1,249	27.5	1,249		5,361	50
51	SINGLESIDED SANDBLASTED URETHANE SIGNS	2001	2,540	169	15	169		592	51
52	DECORATIVE BRICK WALL AROUND PATIO	2001	2,070	75	27.5	75		278	52
53	FIRE ALARM PANEL	2001	2,388	87	27.5	87		315	53
54	SPEED BUMPS - PARKING LOT	2001	3,600	240	15	240		840	54
55	CARPETING-1ST FLR CRDR, NSG OFFICE, ENTRYWAY	2002	12,079	2,319	5	2,416	97	8,697	55
56	LOOSE LAID BALLASTED RUBBER ROOF	2002	46,590	1,694	27.5	1,694		3,882	56
57	F & I. A. O SMITH WATER HEATER	2002	4,600	167	27.5	167		383	57
58	FURNISH & INSTALL BOILER	2003	25,591	930	27.5	930		1,822	58
59	COMPLETE CANTILEVER RE-CONSTRUCTION	2004	14,133	493	27.5	493		493	59
60	INSTALL FLOOR DRAIN AND VENT	2004	834	21	27.5	21		21	60
61	REPLACE OBSOLETE ELEVATOR VALVES AND PARTS	2004	22,539	581	27.5	581		581	61
62	REPLACE SEWER LINE BETWEEN GREASE TRAP & MACH	2004	1,990	27	27.5	27		27	62
63									63
64			SL ADJ	32,849			(32,849)		64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,243,980	$ 75,947		$ 75,947	$	$ 1,220,756	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 506,549	$ 40,831	$ 38,633	$ (2,198)	3-15 YRS	$ 240,244	71
72	Current Year Purchases	70,940	42,683	4,123	(38,560)	3-15 YRS	4,123	72
73	Fully Depreciated Assets	5,633					5,633	73
74	RELATED PARTIES		5,245	5,245				74
75	TOTALS	$ 583,122	$ 88,759	$ 48,001	$ (40,758)		$ 250,000	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,881,987	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 164,706	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,948	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (40,758)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,470,756	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A RELATED PARTY

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 7,889 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY USE	1999 DODGE RAM - VAN	$ 295.13	$ 16,072	17
18					18
19					19
20					20
21	TOTAL		$ 295.13	$ 16,072	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
COMMUNITY COLLEGE	X
HOURS PER AIDE	90

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 306	$	$ 306
2	Books and Supplies		66		66
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 372	$	$ 372
10	SUM OF line 9, col. 1 and 2 (e)	$ 372			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	1

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	$		$ 87,974	$		$ 87,974	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			6,615			6,615	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			74,740			74,740	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				74,481		74,481	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	LAB, X-RAY, I.V. THERAPY Other (specify):	39-2					17,853		17,853	13
14	TOTAL			$		$ 169,329	$ 92,334		$ 261,663	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2004 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,810,535	$ 2,066,632	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 101,734)	760,566	760,566	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	31,747	65,150	6
7	Other Prepaid Expenses	13,026	13,026	7
8	Accounts Receivable (owners or related parties)	104,400	104,400	8
9	Other(specify): ESCROW DEPOSITS		590,579	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,720,274	$ 3,600,353	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	672,781	1,171,469	11
12	Long-Term Investments	1,081	1,081	12
13	Land		50,050	13
14	Buildings, at Historical Cost		995,068	14
15	Leasehold Improvements, at Historical Cost		1,136,945	15
16	Equipment, at Historical Cost	583,119	620,075	16
17	Accumulated Depreciation (book methods)	(508,512)	(1,847,163)	17
18	Deferred Charges		27,384	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 748,469	$ 2,154,909	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,468,743	$ 5,755,262	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 228,510	$ 190,834	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	153,765	153,765	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	80,939	80,939	30
31	Accrued Taxes Payable (excluding real estate taxes)	13,414	13,414	31
32	Accrued Real Estate Taxes(Sch.IX-B)		71,532	32
33	Accrued Interest Payable		9,067	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	MANAGEMENT FEES	514	514	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 477,142	$ 520,065	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		222,836	39
40	Mortgage Payable		2,033,708	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 2,256,544	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 477,142	$ 2,776,609	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,991,601	$ 2,978,653	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,468,743	$ 5,755,262	48

*(See instructions.)

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 2,667,661	1
2	Restatements (describe):		2
3	ROUNDING ADJ.	(2)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 2,667,659	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	423,573	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(85,000)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) REPLACEMENT TAX	(14,631)	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 323,942	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,991,601	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,297,924	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 5,297,924	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	131	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 131	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	52,413	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 52,413	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 5,350,468	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	803,361	31
32	Health Care	1,727,556	32
33	General Administration	1,443,517	33
	B. Capital Expense		
34	Ownership	627,114	34
	C. Ancillary Expense		
35	Special Cost Centers	261,663	35
36	Provider Participation Fee	63,684	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,926,895	40
41	**Income before Income Taxes (line 30 minus line 40)****	423,573	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 423,573	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation.**
TAX RETURN PREPARED ON CASH BASIS

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,084	2,238	$ 69,122	$ 30.89	1
2	Assistant Director of Nursing	1,931	2,165	48,561	22.43	2
3	Registered Nurses	11,803	13,179	317,030	24.06	3
4	Licensed Practical Nurses	14,702	15,999	296,945	18.56	4
5	Nurse Aides & Orderlies	54,335	56,978	605,797	10.63	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,849	2,091	28,847	13.80	9
10	Activity Assistants	14,012	14,589	104,998	7.20	10
11	Social Service Workers	2,988	3,291	45,343	13.78	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	5,668	6,381	80,452	12.61	14
15	Cook Helpers/Assistants	10,940	11,731	91,684	7.82	15
16	Dishwashers					16
17	Maintenance Workers	773	800	10,158	12.70	17
18	Housekeepers	23,615	25,152	227,560	9.05	18
19	Laundry	4,006	4,301	36,734	8.54	19
20	Administrator	1,849	2,091	95,929	45.88	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,907	6,720	92,017	13.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,786	4,187	60,309	14.40	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	160,248	171,893	$ 2,211,486 *	$ 12.87	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	211	$ 9,495	1-3	35
36	Medical Director	72	7,800	9-3	36
37	Medical Records Consultant	4	258	10-3	37
38	Nurse Consultant	152	36,648	10-3	38
39	Pharmacist Consultant	192	1,440	10-3	39
40	Physical Therapy Consultant	29	1,550	10a-3	40
41	Occupational Therapy Consultant		0	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant		0	10a-3	43
44	Activity Consultant	39	2,487	11-3	44
45	Social Service Consultant	11	716	12-3	45
46	Other(specify)				46
47	PSYCHO SOCIAL CONSLT	96	12,000	10-3	47
48	U.R. CONSULTANT	72	7,800	10-3	48
49	TOTAL (lines 35 - 48)	878	$ 80,194		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	10-3	50
51	Licensed Practical Nurses		0	10-3	51
52	Nurse Aides		0	10-3	52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
SUSAN MEAD	ADMIN		$ 95,929
			0
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 95,929

B. Administrative - Other

Description		Amount
RELATED PARTIES	MANAGEMENT FEES	$ 423,400
TOTAL (agree to Schedule V, line 17, col. 3)		$ 423,400
(Attach a copy of any management service agreement)		

C. Professional Services

Vendor/Payee	Type	Amount
		$
SEE SCHEDULE ATTACHED		173,296
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 173,296

D. Employee Benefits and Payroll Taxes

Description		Amount
Workers' Compensation Insurance		$ 45,905
Unemployment Compensation Insurance		30,634
FICA Taxes		167,286
Employee Health Insurance		161,589
Employee Meals		0
Illinois Municipal Retirement Fund (IMRF)*		
EMPLOYEE BENEFITS - OTHER		10,900
EMPLOYEE PHYSICAL EXAMS		2,655
PENSION/PROFIT SHARING PLANS		7,950
CHICAGO HEAD TAX		0
INSURANCE - EXECUTIVE LIFE		0
INSURANCE - EXECUTIVE LIFE	VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)		$ 426,919

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,736
Health Care Worker Background Check	2,352
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	20,880
TRUST/FRANCHISE/CONTRIB/ETC	6,196
LICENSES & PERMITS	3,025
DUES & SUBSCRIPTIONS	6,082
MGMT CO ALLOCATION	644
TRUST/FRANCHISE/CONTRIB/ETC	(6,196)
Less: Public Relations Expense	(11,039)
Non-allowable advertising	(9,841)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 14,839

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
TRAVEL	0
MANAGEMENT COMPANY ALLOC.	6,719
Seminar Expense	
	6,135
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 12,854

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	PAINTING/DECORATIN	06/2001	$ 1,571	3	$ 262	$ 524	$ 524	$ 261	$	$	$	$	$
2	PAINTING/DECORATIN	06/2003	1,623	3			271	541	541	270			
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 3,194		$ 262	$ 524	$ 795	$ 802	$ 541	$ 270	$	$	$

Facility Name & ID Number NORTHWOODS CARE CENTRE # 0044198 Report Period Beginning: 01/01/2004 Ending: 12/31/2004

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL. COUNCIL LONG TERM CARE-$6624**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,117** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **63,684**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees